# IHS Best Practice Model
# Basic Diabetes Care and Education: A Systems Approach

## Why is this important?

Indian health and national studies show that diabetes programs that use a system approach to diabetes care and education result in improved diabetes care services. Indian health diabetes programs have helped define the elements that make up quality diabetes care and education within American Indian/Alaska Native communities. These nine elements are based on recognized standards of care. Programs looking to improve their care delivery system can review these elements and determine which are lacking in their program or which could be enhanced. Activities for each element are described for three levels, with each level building on the earlier one. For example, a program wishing to pursue a Level III step would already have implemented Levels I and II.

## What measures are used?

- The Diabetes Quality Improvement Project (DQIP) is a national diabetes performance and outcome measurement set. DQIP will help health care systems across the U.S. improve diabetes care.

- The Indian Health Diabetes Care and Outcomes Audit is similar to DQIP measures. The system of care described in the nine elements can help programs improve outcomes for audit measures.

## What are the nine elements of quality diabetes care and education?

### 1. Case Management

Case Management has been shown to improve adherence to standards of care and patient outcomes. Two examples might include an RN who coordinates the care of people with diabetes who are seen by contract providers or an RN/CDE who is actively involved in the care and follow-up of a set group of people with diabetes.

Level I: 1 RN coordinates the care and education of the diabetic population.
Level II: RN Case Manager tracks follow-up, appointments not kept, and people with diabetes lost to follow-up. Also coordinates the annual diabetes audit.
Level III: RN Case Manager is an active participant in the care of a set group of people with diabetes. This could include phone or in-office follow-up for blood sugars and blood pressure, facilitating medication refills, and so on.

### 2. Information Management

Whether a program is starting with a hand-kept patient list or is already fluent in the RPMS System, managing information on both individuals and communities helps improve care and demonstrates that the program works! The more we can rely on RPMS (or similar program), the better our information and the less time audits will consume.

Level I: Diabetes Registry, Flowsheet, and Chart Section (manual or automated)
Level II: Automated diabetes management program, including computer-generated health summaries; conducting at least part of the diabetes audit electronically.
Level III: Fully utilize RPMS, including tracking patients with complications, giving providers feedback on their adherence to standards of care, and performing completely automated diabetes audits.

**3. Diabetes Team**

To meet IHS and ADA guidelines, every diabetes program should have a clearly identified Diabetes Team. If possible, the team should minimally consist of an RN and an RD. The Diabetes Team has the responsibility for ensuring the quality of all diabetes care offered at a site.

Level I: Diabetes Team consists of at least an RN and an RD
Level II: Diabetes Team is multidisciplinary both in composition and in delivering services to people with diabetes. Team must include a physician.
Level III: At least one team member should be a CDE and the program should have achieved both Education Program and Provider Recognition by the ADA (or, hopefully, soon the IHS equivalent).

**4. Systems of Care**

There are many ways to deliver quality care and education. The goal is to have a clearly defined system. Many sites have instituted diabetes-specific clinics and also have much of their diabetes care occurring in general or walk-in clinics. The result is often a disparity in the quality of care achieved. Other sites have elected to pursue what is called a Primary Care Model, which focuses on continuity of care with one provider. In addition, there are some newer models, such as Group Medical Visits, which can be incorporated into either the "Diabetes Clinic" or "Primary Care" models.

Level I: Medical care is contracted out, but the non-medical components are provided by the program (e.g. Foot Checks, Education, Nutrition Counseling, etc)
Level II: Complete primary care of diabetes is provided by the program, either in the "Diabetes Clinic" or "Primary Care" model (or a combination).
Level III: Newer models of care are incorporated, such as Group Medical Visits or a Primary care/case manager caring for a defined panel of people with diabetes.

**5. Patient Education**

All quality diabetes programs have a strong education component to help people actively direct their care and manage their diabetes every day.

Level I: A basic body of diabetes knowledge is taught to each patient.
Level II: Organized Education Plan with a defined curriculum and lesson plans.
Level III: Inclusion of empowerment strategies, including support groups, training in coping skills, and problem-solving/behavior-change interventions.

**6. Training Providers and Educators**

All of us involved in diabetes care need to stay up-to-date and refresh our skills. This applies to all providers, not just those directly involved with the Diabetes Team.

Level I: Each member of the Diabetes Team receives basic diabetes training periodically.
Level II: Each member of the Diabetes Team receives a minimum of 12 hours of diabetes-specific training every 2 years.
Level III: Ongoing, coordinated education on-site for all providers, to include training in site-specific information management and documentation issues.

**7. Protocol-based Practice**

Diabetes standards of care can be adapted to local formularies and staffing, allowing many programs to adopt or write their own protocols.

Level I: Promotion of diabetes standards of care knowledge and adherence among providers and people with diabetes.
Level II: Protocol-based medical care (both diabetes team and non-team providers)
Level III: Protocol-based medication adjustments by other members of diabetes team (e.g. RN/CDE, pharmacists).

**8. Specialty Exams and Services**

Diabetes care often requires the services of specialists, both for screening and treatment of complications (e.g. eye, foot. kidney) Whether a site contracts outside for the exams or provides them on-site, ensuring access to specialty care is an essential part of a diabetes system.

Level I: Most/all screening exams and specialty services are provided by contract providers.
Level II: Screening exams and basic services are available on-site.
Level III: Subspecialty services are available on-site.

**9. Staging of Population**

The care needs of people with diabetes change as their disease progresses. Following a patient at high risk for diabetes requires a different set of skills than does management of one experiencing end-stage complications. For example, a program may choose to assign the follow-up of people at high risk for diabetes to an RN and/or an RD, the care of recently diagnosed diabetics to mid-level practitioners, and the care of patients with complications to physicians. This fully utilizes the skills of available staff in a cost-effective manner and matches people with diabetes' needs with the most appropriate providers.

Level I: Optimal use of existing diabetes team specialties.
Level II: Provide prevention/early detection services to people at high risk for diabetes.
Level III: Resources are specifically directed toward the care of people with advanced diabetes complications.

When developing your program grant, you may want to refer to the *Indian Health Integrated Diabetes Education and Care Standards.* This document will help you assess your diabetes program current level of function. You can also use the document to plan ways to improve the quality of diabetes education and care services within your community.